

## Cystic Fibrosis Physician Reporting Form

Please see the reverse side for instruction.

### PART 1

Physician name (last, first): \_\_\_\_\_

Physician telephone: \_\_\_\_\_ Physician fax: \_\_\_\_\_

### Patient Information

Patient's name (last, first): \_\_\_\_\_

Mother's name (last, first): \_\_\_\_\_

Current address: \_\_\_\_\_

DOB: \_\_\_\_\_ Birthing facility: \_\_\_\_\_

### Sweat Chloride Testing

Date of scheduled sweat chloride test: \_\_\_\_\_

Location of scheduled sweat chloride test (select one) (see reverse side for contact information):

- Deaconess Hospital (Evansville)\*  
 Lutheran Hospital (Fort Wayne)\*  
 Riley Hospital for Children (Indianapolis)\*  
 St. Joseph Regional Medical Center (South Bend)\*  
 Other laboratory (please list) \_\_\_\_\_
- \* = Cystic Fibrosis Foundation accredited laboratories

\*\*\*\*\*Please submit the above information to ISDH after sweat chloride test scheduled\*\*\*\*\*

\*\*\*\*\*Complete the information below & resubmit to ISDH after sweat chloride results received\*\*\*\*\*

### PART 2

Date sweat chloride test results received: \_\_\_\_\_

Results of sweat chloride testing (select one):

- Normal  
 Borderline  
 Positive  
 Inadequate sample / invalid sweat chloride test  
 Patient failed appointment / test rescheduled for other reason (please list): \_\_\_\_\_

Date and location of rescheduled sweat chloride test: \_\_\_\_\_

Where was patient referred for follow-up care? (select all that apply)

- Deaconess Hospital (Evansville)\*  
 Lutheran Hospital (Fort Wayne)\*  
 Riley Hospital for Children (Indianapolis)\*  
 St. Joseph Regional Medical Center (South Bend)\*  
 Geneticist / genetic counselor (please list) \_\_\_\_\_  
 Other clinic / specialist (please list) \_\_\_\_\_
- \* = Cystic Fibrosis Foundation accredited centers

### Instructions for Physician Reporting Form

This is a two-part reporting form. Please fax the Physician Reporting Form to the CF Coordinator at the Indiana State Department of Health once each part has been completed.

#### Part 1

1. Please complete top section with the appropriate information.  
\*In group practices, use information for individual primary care physician.
2. **Completion of the "Sweat Chloride Testing" section is very important.** Please note that the labs listed in this section are the only CFF-accredited laboratories in the state of Indiana. If the patient is scheduled at a laboratory not included in the list, please report the full name of the laboratory, hospital affiliation (if any), and contact phone number.
3. When **PART 1** has been completed, please fax the form to ISDH, **Attention: Malorie Hensley**, at (317) 234-2995.

#### Part 2

1. Once you have received the sweat chloride test results, please complete **PART 2**.
2. **If applicable**, please provide the date and location of a repeat / rescheduled sweat test.
3. Please indicate **all** referrals made for the patient.  
\*In group practices, use information for individual primary care physician.
4. When **PART 2** has been completed, please fax the form to ISDH, **Attention: Malorie Hensley**, at (317) 234-2995.